MONTANA
CHILDREN'S HEALTH INSURANCE PLAN

DENTAL PROVIDER MANUAL

Montana CHIP
Children's Health Insurance Plan

JUNE 2000

(Updated 01/14/03)

Montana Department of Public Health and Human Services

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GENERAL INFORMATION

Address and Telephone Reference

Mail claims to: ACS
P.O. Box 8000
Helena, MT 59604

For claims processing information, call or write:

Provider Relations
P.O. Box 4936
Helena, MT 59604

Helena and Out of State Providers: (406) 442-1837
In-State Montana Providers: **1-800-624-3958**

CHIP beneficiary eligibility information:

Automated Voice Response **1-800-714-0060**

Use Automated Voice Response through a touch-tone phone to verify if a CHIP beneficiary has eligibility on a particular date of service. Your CHIP provider ID number and the child's SSN are needed to access this system.

Faxback **1-800-714-0075 (Fax)**

Faxback will Fax a report of the CHIP beneficiary's eligibility. To sign up for Faxback, call ACS at 1-800-624-3958 (in-state providers) or (406) 442-1837 (Helena and out-of-state providers). A CHIP provider number and FAX number are needed to sign up for this service. Your CHIP provider ID number and the child's SSN are needed to access this system.

Automated Voice Response and Faxback do not check program benefit limits. Information on benefit limits can only be obtained by contacting the ACS Provider Relations Unit directly. Information on benefit limits is not a guarantee of payment. Information is available only for claims that have been processed. Claims that have been submitted, but not yet processed, may affect benefit limits.

ACS Provider Relations (PR) Unit **1-800-624-3958 (in-state providers) or (406) 442-1837 (Helena and out-of-state providers)**

The Provider Relations Unit is available to answer inquiries regarding beneficiary eligibility, service limits, and provider payment issues. Telephone lines are open Monday through Friday, 8 a.m. to 5 p.m.

How to Write for Help

Written inquiries allow ACS time to research complicated billing or eligibility questions more thoroughly and provide more detailed information. In addition, written responses provide a permanent record for future reference.

Use of the Provider Inquiry Form will expedite responses to written inquiries (see **Ordering Claim Forms**). Mail completed form to:

ACS
Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

ACS will mail a response to written inquiries within three working days of receipt.

How to Get On-Site Help

ACS Provider Field Representatives can make on-site visits to train office staff on CHIP billing procedures or to resolve claims payment issues. Contact the provider relations unit to arrange a visit.

Ordering Claim Forms

ACS supplies the following forms for CHIP:
- Adjustment Request
- Claim Inquiry Form
- Eligibility Inquiry Form (SRS-456)
- Provider Inquiry

ADA forms are not supplied by ACS.

For information about becoming a Blue CHIP Medical-Dental Provider, contact:

Blue Cross Blue Shield of Montana
Provider Relations
Box 4309
Helena, MT 59604
(406) 447-8787

Medical-dental services are covered through the child's CHIP insurance plan. Dentists should contact the insurance plan directly to become a medical-dental provider.

Department Responsibilities

The Montana Department of Public Health and Human Services (Department) administers the Children's Health Insurance Plan (CHIP) in Montana. CHIP was created by Congress to serve children from families with limited financial resources, who do not qualify for Medicaid and who do not have health insurance. Montana has chosen to purchase private insurance coverage for the majority of health services available to CHIP beneficiaries. Dental services (with the exception of medical dental services) and eyeglasses are provided through private providers who contract with the Department. The Department is responsible for determining payment rates, benefit coverage, and beneficiary eligibility. The Department conducts oversight through retrospective utilization review.

This manual is a guide for the dental provider filing claims with CHIP. The manual is to be read and interpreted in conjunction with Federal regulations, State statutes, administrative procedures, and Federally approved State Plan amendments. This manual does not take precedence over Federal regulation, State statutes, or administrative procedures.

For policy questions other than eligibility, call or write:

CHIP Section
Department of Public Health and Human Services
P.O. Box 202951
Helena, MT 59620-2951
(406) 444-5288

Fiscal Agent Responsibilities

ACS is the fiscal agent for dental services for CHIP in Montana. ACS processes claims and adjustments and responds to provider inquiries regarding claim status and payments.

Updating This Provider Manual

Providers will be notified of changes in CHIP policy through updates to this provider manual. Please keep your manual current by replacing existing pages with these revisions**.** If you misplace an update, call ACS's Provider Relations Unit at (406) 442-1837 or 1-800-624-3958 and request a copy of the missing update. This manual should be made available to billing personnel and referred to as billing or reimbursement questions arise.

NOTES

Chapter 1
Verifying CHIP Eligibility

How to Verify Eligibility

CHIP beneficiary eligibility must be verified at each provider visit. The easiest way to do this is to ask the responsible family member if the child is eligible for CHIP on the date of service and what the child's CHIP ID number is. This is usually the child's Social Security Number. Accurate recording of the nine (9) digit CHIP eligibility ID number is essential. Payment cannot be made for claims with incorrect CHIP ID numbers.

The Department does not issue an eligibility card for CHIP dental benefits. The beneficiary will receive an insurance card with the CHIP identification number. The insurance card is issued when a child is first enrolled in CHIP and is not re-called if CHIP enrollment ends, so they cannot always be relied on to verify *current* eligibility.

A provider may also utilize one of the eligibility verification systems outlined in the General Information section on Page i of this manual to verify eligibility.

Failure of Eligible CHIP Beneficiary to Notify Provider of CHIP Eligibility

A CHIP beneficiary must notify a provider that he or she has CHIP benefits. If the beneficiary fails to do this, he or she is responsible for the bill unless the provider agrees to discontinue billing the beneficiary and to submit a claim to CHIP.

If the provider agrees to bill CHIP, timely filing limits and coverage limits are applied. The CHIP dental benefit is $350 in a benefit year. The portion of a claim that would be covered under this benefit must be refunded to the CHIP beneficiary prior to billing CHIP. The beneficiary can no longer be billed for the CHIP covered portion of the bill. (See Chapter 2, Reimbursement, Covered, and Non-Covered Services, for more information.)

NOTES

Chapter 2
Reimbursement, Covered, and Non-Covered Services

CHIP Reimbursement

Dental services will be reimbursed at 85% of the billed charges up to $350 per benefit year by CHIP.

- Providers may not balance bill the child's guardian for the remaining 15% of billed charges.
- Providers may bill the child's guardian for services in excess of $412 ($412 x 85% = $350 annual CHIP benefit).
- Non-medical dental services provided to a CHIP beneficiary must be billed to CHIP. Medical dental services are covered under the child's CHIP insurance plan.

Payment from CHIP is payment in full for a covered service. Providers may **never** bill the CHIP beneficiary for:

- Billing errors that cause a claim to be denied, such as a wrong procedure code; an incorrectly completed claim form; or submission of a claim more than 365 days after the date of service.
- The balance between the $350 CHIP annual benefit and the first $412 in charges ($412 x 85%=$350).

A provider **can** bill the CHIP beneficiary if:
- The beneficiary has been given a written explanation that a service is non-covered and he or she is responsible for the charges.
- The beneficiary is not CHIP eligible at the time services are provided.
- The beneficiary has exceeded the CHIP dental benefit of $350 per benefit year. This would equate to $412 in charges.

Providers must comply with all applicable State and Federal statutes, rules and regulations. These include the United States Codes governing CHIP and all applicable Montana statutes and rules governing licensure and certification. Providers must also comply with the requirements governing Medicaid to the extent that these provisions are not inconsistent with the CHIP rule requirements.

Determining CHIP Reimbursement

CHIP pays 85% of billed charges up to $350 per beneficiary in a benefit year for dental services. (A benefit year is October 1 through September 30 of the following year.) Thus for the first $412 of a provider's charges, CHIP pays $350 ($412 x 85% = $350). This payment amount of $350 is payment in full for a covered service. A CHIP beneficiary may not be billed the difference (15%) between the CHIP payment amount and the provider's charges. Once a CHIP beneficiary is accepted as a patient, you may not agree to take CHIP reimbursement for some services and not for others.

The $350 CHIP Dental Services Cap is applicable to each beneficiary per plan year (October – September). Your services and those services provided by other dentists are applied to this cap.

Example: **A child needs a tooth repaired with a Resin-Four Surfaces Fractured Anterior Repair Permanent (D2335). The Dentist charges $150 for this service.**

Billed charges	$150.00
CHIP reimbursement percentage—85%	.85
CHIP allowed amount	$127.50
CHIP reimbursement cap	$350.00
CHIP reimbursement cap used YTD	$.00
CHIP payment for service	$127.50

The same child returns a month later and needs a Complete Root Canal Therapy— molar (D3330). The dentist charges $400 for this procedure.

Billed charges	$400.00
CHIP reimbursement percentage—85%	.85
CHIP allowed amount	$340.00
CHIP reimbursement cap	$350.00
CHIP reimbursement cap used YTD	$127.50
CHIP payment for services*	$222.50

Amount billable to the beneficiary:

Billed charge for the service	$400.00
Less charges applicable to CHIP ($222.50 ÷ .85)	$261.76
Line item charges billable to the beneficiary	$138.24

**An EOB code will appear on your Remittance Advice indicating the line item service billed was reduced or paid at zero because the $350 CHIP Dental Services Cap has been met. A portion of the line item charges may then be billable to the beneficiary. To determine the amount billable to the beneficiary use the following formula:*

Billed Charges – (CHIP Payment ÷ .85) = Line Item Amount Billable to the Beneficiary

Billing the Beneficiary

When the $350 patient dental benefit is exhausted, the CHIP beneficiary is responsible for payment for any additional services he or she wishes to have the provider perform. The CHIP program will not enter into any dispute between the provider and the beneficiary regarding billing and payment issues. To avoid any misunderstandings with CHIP beneficiaries, providers are advised to obtain written confirmation from CHIP beneficiaries whenever private payment arrangements are contemplated.

The CHIP beneficiary is also responsible for any services not covered by CHIP.

Covered Services

All non-medical dental services are covered by CHIP, with the exception of those services listed below under Non-Covered Services.

Non-Covered Services

The following series of services described by ADA CDT-3 codes are not covered benefits of CHIP:

D5900 – D5999 Maxillofacial Prosthetics
D6000 – D6199 Implant Services
D7610 – D7780 Treatment of Fractures
D7920 – D7999 Other Repair Procedures
D8000 – D8999 Orthodontics

Medical-dental services provided to a CHIP beneficiary must be billed to the child's CHIP insurance plan.

In addition, CHIP does not cover experimental services, services generally regarded by dental professionals as unacceptable treatment, or any treatments that are not medically necessary.

Usual and Customary Charges

All charges for services submitted to CHIP must be made in accordance with an individual provider's **usual and customary** charges to the general public.

No-Show Appointments

Canceled or missed appointments by CHIP beneficiaries **cannot** be billed to CHIP. If your office policy is to bill **all** patients for canceled or missed appointments, CHIP beneficiaries may be billed for any no-show appointments.

Medical Necessity

All claims are subject to post-payment review for medical necessity by CHIP. Clinical records should substantiate the need for service by including the findings and information to support medical necessity and detailing the care rendered. If upon post-payment review the Department determines that services are not medically necessary, payment will be denied and action will be taken to recoup payment for those services. If the Department determines that a service was not medically necessary, the provider may not bill the CHIP beneficiary.

Each CHIP patient's clinical record must include sufficient documentation to enable the Department to determine the appropriateness of the treatment performed without requiring a patient examination. Each CHIP clinical record shall include, at a minimum, documentation of clinical diagnoses, pertinent medical and dental history, a treatment plan, complete anesthesia record if applicable, and any radiographs used to facilitate the development of the treatment plan. CHIP clinical records shall be maintained for six (6) years and three (3) months.

Chapter 3
Billing Instructions

Important Billing Guidelines

- Be sure to enter your CHIP provider number on line 24 of the 1994 ADA Claim Form.
- The Department prefers Electronic Media Claim (EMC) transmission.
- If using paper claims, the **1994 ADA Dental Claim form** (Exhibit 3.1) is the preferred billing form. Other versions of the ADA claim form will be accepted.
- CDT-3 codes must be used.
- Use one claim per CHIP beneficiary.
- Claims must be submitted within 365 days of services.
- Date of submission is the date the claim is stamped as received by ACS or the Department. If a claim is lost in the mail, the claim is not considered received.
- Information on the form must be legible.
- A "clean" or problem-free claim is usually processed within 35 days of receipt.
- A check for claims approved for payment will be mailed in the same envelope with the Remittance Advice.

Coding Requirements – Current Dental Terminology, Third Edition (CDT-3)

Montana CHIP Coding Guidelines: CDT-3 codes and their respective definitions were developed by the American Dental Association. These codes are used by CHIP for claim adjudication. Montana CHIP has established specific guidelines for covered services and reimbursement. (See Chapter 2, Reimbursement, Covered, and Non-Covered Services, for details).

Types of Electronic Data Interchange (EDI) Transmissions

ACS accepts several forms of electronic media including:

- Diskettes
- Direct Entry (via telephone modem with PC)
- Magnetic Tape
- File Transfer Protocol (FTP)

Submitting claims via electronic media speeds claims processing and increases accuracy. Providers may submit claims through an electronic medium or choose from several firms that offer electronic claim submission services for a small per claim fee. A provider contracts with a vendor to submit claims via one of the above methods.

Software Available from ACS

ACS has developed windows-based software that enables providers to submit claims electronically. The ACE$ software package is supplied **free of charge**. ACE$ allows a provider to enter CHIP claims on a personal computer (PC). Claims are transmitted via telephone line directly to ACS. If a PC does not have a modem, store the claims data on a diskette and mail the diskette to ACS for direct input.

ACE$ software is available to any provider who has a computer that meets these minimum requirements:

- Pentium 90 Mhz
- 16 MB RAM
- 25 MB free hard drive space
- 9600+ baud rate modem
- Windows 95/98/NT 4/2000
- CD Rom

Cost

Providers are responsible for securing their own PC equipment, associated operating supplies, and modem to transmit via telephone lines.

Training

An Electronic Data Interchange Specialist is available 8 a.m. to 5 p.m. weekdays to provide technical support to providers who use ACE$. Call the Provider Relations Unit at 1-800-624-3958 (in-state providers) or 406-442-1837 (Helena and out-of-state providers). A Provider Field Representative can assist in installing ACE$ application software on-site and help with initial testing and instructions for ongoing claims submissions.

Paper Submission of Claims—ADA Dental Claim Form

The American Dental Association (ADA) 1994 Dental Claim is the preferred paper form for billing dental services authorized under the Montana CHIP Dental Program. ACS will accept ADA claim forms other than the 1994 version. Please be aware that alternate ADA claim forms must contain all the information required on the 1994 claim form. Use of alternate forms increases the risk of keying errors.

ACS does not supply the ADA Dental Claim Form. The ADA Dental Claim Form may be ordered from an independent printer or ADA Catalog Sales at 1-800-947-4746.

Exhibit 3.1
1994 ADA Dental Claim Form

Dental Claim Form See reverse for instructions

1.	2.	3. Carrier name and address
☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services Provider ID #	☐ Medicaid Claim ☐ EPSDT Prior Authorization # Patient ID #	

PATIENT COVERAGE INFORMATION

4. Patient name (first / m.i. / last)	5. Relationship to employee	6. Sex (m / f)	7. Patient birthdate (MM DD YYYY)	8. If full time student (school / city)
	☐ self ☐ child ☐ spouse ☐ other			

9. Employee/subscriber name and mailing address	10. Employee/subscriber dental plan I.D. number	11. Employee/subscriber birthdate (MM DD YYYY)	12. Employer (company) name and address	13. Group number

14. Is patient covered by another dental plan (yes / no). If yes, complete 15-a. Is patient covered by a medical plan? (yes / no)	15-a. Name and address of carrier(s)	15-b. Group no.(s)	16. Name and address of other employer(s)

17-a. Employee/subscriber name (if different from patient's)	17-b. Employee/subscriber dental plan I.D. number	17-c. Employee/subscriber birthdate (MM DD YYYY)	18. Relationship to patient
			☐ self ☐ parent ☐ spouse ☐ other

19. I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.	20. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.
Signed (Patient* – see reverse) Date	Signed (Employee/subscriber) Date

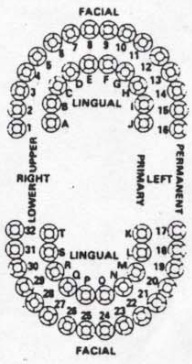
BILLING DENTIST

21. Name of Billing Dentist or Dental Entity	30. Is treatment result of occupational illness or injury? (No / Yes)	If yes, enter brief description and dates
22. Address where payment should be remitted	31. Is treatment result of auto accident?	
23. City, State, Zip	32. Other accident?	

24. Dentist Soc. Sec. or T.I.N. (see reverse**)	25. Dentist license no.	26. Dentist phone no.	33. If prosthesis, is this initial placement?	(If no, reason for replacement)	34. Date of prior placement

27. First visit date current series	28. Place of treatment (Office / Hosp. / ECF / Other)	29. Radiographs or models enclosed? (No / Yes / How many?)	35. Is treatment for orthodontics?	If service already commenced enter:	Date appliances placed	Mos. treatment remaining

36. Identify missing teeth with "x"



37. Examination and treatment plan – List in order from tooth no. 1 through tooth no. 32 – Using charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year	Procedure number	Fee

For administrative use only

38. Remarks for unusual services

39. I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

Signed (Treating Dentist) License Number Date

40. Address where treatment was performed

City State Zip

41. Total Fee Charged	
42. Payment by other plan	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

J510 (Same as ADA Dental Claim Form - J504, J511, J512)

Instructions for Completing the ADA Dental Claim Form

Claim Item	Title	Req'd.	Action
2	Medicaid Claim, EPSDT, Prior Authorization No., Patient ID No.		(Optional) Enter the patient account number you use for internal record keeping. **Do not enter the beneficiary's ten-digit CHIP ID number here.**
4	Patient name	X	Enter the beneficiary's first name, middle initial, and last name as it appears on the CHIP ID Card.
10	Employee/subscriber dental plan ID number	X	**Enter the beneficiary's nine-digit CHIP ID number.** (Usually the beneficiary's SSN.)
21	Name of Billing Dentist or Dental Entity	X	Enter the name of your practice.
22	Address where payment should be remitted	X	Enter the address of your practice.
23	City, State, Zip	X	Enter the city, state, and zip code.
24	Dentist's Social Security or Tax ID Number	X	**Enter your seven-digit CHIP Provider Number.** *This is the number to which payment will be made.*
37	Examination and treatment plan	X	The following information is required for **each** CDT procedure code billed to CHIP: (description not required) - **Tooth # or letter (when applicable)** - **Surface or quadrant (when applicable) Enter the appropriate surface or quadrant code:** **B Buccal surface** **D Distal surface** **F Facial surface** **I Incisal surface** **L Lingual surface** **LL Lower left quadrant** **LR Lower right quadrant** **M Mesial surface** **O Occlusal surface** **UL Upper left quadrant** **UR Upper right quadrant** - **Date service performed**

Claim Item	Title	Req'd.	Action
			- **Procedure number (must use full five-digit CDT-3 procedure code)** - **Fee (usual and customary charge for the procedure)** **If any of the required information is missing or incomplete, your claim will be denied.**
39	Dentist's signature box	X	Sign and date the claim. A personal signature, a stamped facsimile signature, typed signature, computer generated name, or an authorized signature, and date must appear in the field. Providers are responsible for all claims billed using their Montana CHIP Provider Number whether the claim is submitted by the provider, the provider's employee, subcontractor, vendor, or business agent.
41	Total Fee Charged	X	Add together all of the fees listed in item 37 and enter the total amount in this field.

Authorized Signatures

All claims must be signed by the provider or an authorized representative. The signature may be handwritten, a stamped facsimile, typed, computer generated, or the signature of an authorized representative. The signature certifies that all information on the claim is true, accurate, complete, and contains no false or erroneous information.

Where to Send Claims

Send completed ADA Dental Claim Forms to:

ACS/Claims
P.O. Box 8000
Helena, MT 59604

Timely Filing

Providers must submit a "clean claim" within 365 days of the date of service. A "clean claim" is one that can be processed for payment without correction or additional information or documentation from the provider.

Timely filing cannot be waived when a claim is denied due to provider billing errors.

Follow-up on Claim Resolution

Timely follow-up of claims is the provider's responsibility. **Events beyond a provider's control may affect claims. Regardless of the cause of the problem, it is the provider's responsibility to initiate appropriate action and follow-up to get claims issues resolved within the 365 day filing limit. The Department and ACS will not know if a claim is lost in the mail or if a keying error is made. A provider is the only one who can identify when these problems occur and when assistance is necessary to resolve them.**

It is important for providers to review paid and denied claims on each remittance advice and take corrective action to resolve denied claims. Correction of the problems listed on the remittance advice does not guarantee all problems have been resolved. The system will report all problems identified at the time the claim is processed. Additional errors may occur at the time of resubmission. ACS Provider Relations staff is available to assist a provider who is having difficulty correcting and resubmitting a claim.

How to Appeal Timely Filing Denials

The provider appeal should be filed with CHIP Section, Department of Public Health and Human Services, P.O. Box 202951, Helena, MT 59620-2951, and include the following:

- documentation of previous claim submission
- an explanation of the problem
- a clean copy of the claim, along with any required documentation

Billing Tips to Avoid Timely Filing Denials

- File claims as soon as possible after services are provided.
- Carefully review error denial codes on the Remittance Advice including detail denial lines and additional errors reported beneath each claim.
- Resubmit the entire claim or denied detail line after ALL corrections have been made.
- Prior to resubmitting a claim, contact ACS if you have any questions regarding billing or denials.
- If you have not received payment within 45 days of submission, contact ACS regarding the status of the claim.
- If you have had multiple denials on a claim, contact a Provider Field Representative at ACS and request a review of the denials prior to resubmission.

Important: Once a provider has agreed to accept a CHIP patient, any loss of CHIP reimbursement due to provider failure to meet timely filing deadlines is the responsibility of the provider. The provider may not bill the family for any service within the $350 cap.

The Remittance Advice

The Remittance Advice (RA) summarizes the status of claims submitted to CHIP for payment— whether they were paid, suspended, or denied. Aside from providing a record of transactions, the RA assists in resolving possible errors. Refer to Page 3-8 for a sample RA and Page 3-9 for instructions on how to read the RA.

- Claims are grouped by disposition category. For example, paid, denied, and suspended claims and claim adjustments are listed in separate sections.
    - *Claim Status—**PAID*** group contains all the paid claims. If a claim has been paid that should not have been billed to CHIP, refer to **How to File a Void or Adjustment Request** in this chapter for instructions. ***Only a paid claim can be voided or adjusted.***
    - *Claim Status—**DENIED*** group reports denied claims. A denied claim can be resubmitted with new or additional information (see **How to Resubmit a Denied Claim** in this chapter).

- *Claim Status—**SUSPENDED*** group reports claims suspended for review. Do not rebill these claims. ***Suspended claims cannot be adjusted or voided.*** All claims in suspended status are reported each payment cycle until paid or denied.

- All paid, denied, and suspended claims and claim adjustments are itemized within each group in alphabetical order by beneficiary last name.

- Internal Control Numbers (ICNs) are assigned to all of the claims in the batch as they are microfilmed. The ICN assigned to each claim allows the claim to be tracked throughout the Montana CHIP system. The digits and groups of digits in the ICN have special meanings, as explained in this example:

```
0          00010          11       500      0001    00
|          |              ||       |        | |      |
|          |              ||       |        | |      Line number
|          |              ||       |        | |
|          |              ||       |        | Claim Number
|          |              ||       |        Type of document (0=new claim, 1=credit, 2=adjustment)
|          |              ||       Batch number
|          |              |Microfilm reel number
|          |              Microfilm machine number
|          Year/Julian date
Claim input medium indicator
    0=Exam entered paper claim
    2=Electronic
    4=Computer generated
```

The RA Summary Section reports the number of claim transactions, and total payment, or check amount.

Exhibit 3.2
Sample Remittance Advice

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
HELENA, MT 59604

MEDICAID REMITTANCE ADVICE

PROVIDER# 0005510000 (1) REMIT ADVICE #141104 MMIS REF#123332 DATE: 04/01/00 (2)

JOHN R. SMITH DDS
2100 NORTH MAIN STREET
WESTERN CITY MT 59988

RECIP ID (3)	NAME (4)	SERVICE DATES FROM (5)	TO (5)	UNIT OF SVC (6)	PROCEDURE REVENUE NDC (7)	TOTAL CHARGES (8)	ALLOWED (9)	EOB CODES (10)
PAID CLAIMS - MISCELLANEOUS CLAIMS								
111111111	DOE, JOHN EDWARD	011500	011500	1	D0120	35.00	23.39	219
(11)	ICN 00003211500002300							
DENIED CLAIMS - MISCELLANEOUS CLAIMS								
222222222	DOE, EDWARD (12)	010500	011500	1	D5120	500.00	350.00	212
	ICN 00003211500002400							
PENDING CLAIMS - MISCELLANEOUS CLAIMS								
333333333	DOE, JANE	010100	010100	1	D0120	35.00	0.00	901
	ICN 00003211500002300	010100	010100	2	D0210	25.00	0.00	901

********** THE FOLLOWING IS A DESCRIPTION OF THE EOB CODES THAT APPEAR ABOVE **********

212 SERVICES DENIED. THE PROVIDER IS A CHIP ONLY PROVIDER AND THE RECIPIENT IS NOT A CHIP CLIENT.

219 LINE PAYMENT REDUCED OR PAID AT ZERO. CHIP DENTAL SERVICES CAP AT $350 FOR EACH RECIPIENT PER PLAN YEAR (OCTOBER - SEPTEMBER). PLEASE USE THE FORMULA: CHARGES - (CHIP PAYMENT DIVIDED BY .85) TO DETERMINE THE LINE AMOUNT BILLABLE TO THE PATIENT.FICE) TO HAVE THE PROBLEM CORRECTED.

901 CLAIM SUSPENDED FOR A MAXIMUM OF 30 DAYS PENDING RECEIPT OF RECIPIENT ELIGIBILITY INFORMATION.

How to Read Your Remittance Advice

Each claim processed during the bi-weekly cycle is listed on the Remittance Advice with the following information:

RA ITEM	TITLE	WHAT ITEM MEANS
1	Provider # & Remit Advice #	Montana CHIP provider number and remittance advice number
2	Date	Date the remittance advice was issued and provider name and address sent to
3	Recip ID	Beneficiary ID billed on the claim
4	Name	Beneficiary name on file with ACS for the ID billed
5	Service Dates From To	Dates of service billed on the claim
6	Unit of SVC	Number of units billed on the claim
7	Procedure Revenue NDC	Procedure code, revenue code or NDC billed on the claim
8	Total Charges	Provider's submitted usual and customary charge for the procedure code
9	Allowed	Amount allowed by CHIP for the procedure code
10	EOB Codes	Explanation of Benefits: Codes that explain why a service was denied. A translation of these codes is included in the final summary at the end of the Remittance Advice.
11	ICN	Internal Control Number: The unique identifying number assigned to each claim submitted.
12	Additional EOB	Additional Explanation of Benefits: Codes that explain why a service was denied. A translation of these codes is included in the final summary at the end of the Remittance Advice.

How to Resubmit a Denied Claim

Check the Remittance Advice before submitting a second request for payment. Claims should be resubmitted if:

- The claim has not appeared on a Remittance Advice as paid, denied, or suspended and it has been thirty days since the claim was submitted; or
- The claim was denied due to incorrect or missing information.

Resubmit the claim on a new claim form or a legible photocopy after correcting any error or attaching requested documentation. Claims and attachments that cannot be clearly microfilmed or photocopied will be returned.

Adjustments

If a provider feels that a claim has been paid *incorrectly* and wishes the claim to be adjusted, the provider must submit an Individual Adjustment Request Form to ACS.

An adjustment is a **post payment** request by a provider to adjust a specific claim. No adjustment request form can be submitted until a claim has been paid. **Denied claims cannot be adjusted.**

A provider should fill out the Adjustment Request Form, attach a copy of the related Remittance Advice, and submit the form to ACS. ACS screens the adjustment requests for completeness and timely filing.

Adjustment request forms must be submitted in accordance with the timely filing requirements. Incomplete forms or those that are not received within the filing limit will be returned to the provider. Adjustment request forms that pass the initial screening are submitted for processing.

How to File a Void or Adjustment Request

Adjustment requests must be submitted on the Adjustment Request Form. All pertinent information must be provided. Adjustment requests **will not** be accepted by telephone. **Correct all errors on the original claim form with one adjustment request by attaching a copy of the claim or Remittance Advice with corrections made in red ink.** Adjustments and voids are processed as replacement claims. In processing, the original payment is completely deducted and the adjustment is processed as a regular claim. The net result is a transaction that will increase or decrease your check.

Exhibit 3.3
Individual Adjustment Request

MONTANA
INDIVIDUAL ADJUSTMENT REQUEST

INSTRUCTIONS:
This form is for providers to correct a claim which has been **paid** at an incorrect amount or was **paid** with incorrect information. Complete all the fields in Section A. with information about the **paid** claim from your statement. Complete ONLY the items in Section B, which represent the incorrect information that needs changing.

A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

1. PROVIDER NAME & ADDRESS

_____

Name

_____

Street or P.O. Box

_____

City State Zip

2. RECIPIENT NAME

_____

3. INTERNAL CONTROL NUMBER (I.C.N.)

_____

4. PROVIDER NUMBER

_____

5. RECIPIENT NUMBER

_____

6. DATE OF PAYMENT _____

7. AMOUNT OF PAYMENT $ _____

B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

	DATE OF SERVICE OR LINE NUMBER	INFORMATION ON STATEMENT	CORRECTED INFORMATION
1. Units of Service			
2. Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)			
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other / REMARKS (BE SPECIFIC)			

SIGNATURE _____ DATE _____

When the form is complete, attach a copy of the payment statement (RA) and a copy of the claim (unless you bill electronically).

MAIL TO: Consultec
P.O. Box 8000
Helena, MT 59604

How to Complete the Adjustment Request Form

Section	Field #	Field Name	Action
A	1	Provider Name & Address	Enter provider name and address indicated on the Remittance Advice (RA).
	2	Beneficiary Name	Enter the beneficiary name as indicated on the RA.
	3	Internal Control Number	Enter the 17-digit internal control number assigned to each claim from the RA.
	4	Provider Number	Enter seven-digit CHIP provider number from the RA.
	5	Chip Beneficiary Number	Enter the nine-digit CHIP Beneficiary ID number (usually SSN).
	6	Date of Payment	Enter the payment date appearing on the RA.
	7	Amount of Payment	Enter the amount allowed indicated on the RA.

Section	Field #	Field Name	Action
B	1	Unit of Service	Changes in units of service
	2	Procedure Code/ NDC/Revenue Code	Changes in procedure code, NDC or Revenue code
	3	Dates of Service (DOS)	Changes in dates of service
	4	Billed Amount	Changes to the billed amount
	5	Personal Resource (Nursing Home)	Changes in a recipients personal resource
	6	Insurance Credit Amount	Changes in another insurance credit or payment from another insurance company
	7	Net (Billed – TPL or Medicare Paid)	Changes in other resource payments
	8	Other/REMARKS	Enter the specific reason for this adjustment and any pertinent information to assist ACS in processing this adjustment.

Chapter 4
Provider Responsibilities

Provider Number

Providers who bill both Montana CHIP and Montana Medicaid have separate provider numbers for each program. The CHIP provider number must be used when submitting a CHIP claim. Example:

Montana Medicaid Provider Number:	1100XXX
Montana CHIP Provider Number:	5500XXX

Claims for CHIP beneficiaries that are billed with the Medicaid provider number will be denied with a message that the beneficiary is a CHIP patient and the provider type is not allowed. Claims for Medicaid recipients billed under the CHIP provider number will also be denied.

Changes in Provider Enrollment

If any information you listed on your original provider enrollment application subsequently changes, you must notify ACS in writing. Examples include, but are not limited to, change of address, change of tax identification number, cessation of practice, and lapse of license.

Send provider enrollment changes to:
ACS
Provider Enrollment Unit
P.O. Box 4936
Helena, MT 59604

Recertification

Each year, ACS will request a copy of your license or other certification. This documentation must be submitted within 60 days of the request.

Provider Participation

A provider may choose to stop participating in the Montana CHIP program at any time. Thirty days' written notice of voluntary termination is requested. Notice should be addressed to ACS.

Montana CHIP can terminate a provider's participation in CHIP for fraud, abuse, or other mis-utilization of services. Reinstatement will be contingent upon provisions of State law.

Providers convicted of fraud or abuse in the Medicaid or Medicare program may not participate in CHIP.

Accepting CHIP Patients—Provider-Patient Relationship

A dental provider can decide whether or not to become a CHIP provider and how many CHIP beneficiaries to accept. This is true whether the beneficiary is new to the provider or is a current patient who becomes eligible for CHIP. Providers must, however, notify CHIP beneficiaries *prior to accepting them as a patient* whether they will be accepted as a CHIP patient or if the provider will only see them as a private pay patient. If a provider fails to fulfill this responsibility and an individual is a CHIP beneficiary, the state will assume that CHIP payment will be accepted. If a CHIP beneficiary and the provider cannot agree on the financial terms of their relationship, either party can sever the relationship. As with any other patient, providers should ensure that services to a patient are not terminated in a manner that could be considered a violation of professional ethics considerations.

Record Keeping, Retention, and Access

The Provider Agreement requires that clinical records fully disclose the extent of services provided. Clinical record documentation should meet the following standards:

- The record must be legibly written.
- The record must identify the patient on each page.
- Entries must be signed and dated by the responsible licensed participating provider. Care rendered by personnel under the direct, personal supervision of the provider, in accordance with CHIP policy, must be countersigned by the responsible licensed, participating provider.
- The record must contain a preliminary working diagnosis and the elements of a history and physical examination upon which the diagnosis is based.
- All services, as well as the treatment plan, must be documented in the record. Any drugs prescribed as part of a treatment, including the quantities and the dosage, must be entered in the record.
- The record must indicate the observed medical condition of the patient, the progress at each visit, any change in diagnosis or treatment, and the patient's response to treatment.
- Progress notes must be written for each visit billed to CHIP.

Providers must retain clinical and financial records, including information regarding dates of service, diagnoses, services provided, and bills for services, for at least six years and three months from the end of the Federal fiscal year (October 1 through September 30) in which the services were rendered. If an audit is in progress, the records must be maintained until the audit is resolved.

CHIP providers must allow access to all records concerning services and payment to authorized personnel of the Montana Department of Public Health and Human Services, United States Department of Health and Human Services, State Auditor's Office, Montana Attorney General's

Office, and their designees. Records must be accessible to authorized personnel during normal business hours for the purpose of reviewing, copying, and reproducing documents. These entities shall have access to records even if the provider chooses to no longer participate in the program. Providers must furnish copies of claims and any other documentation upon request.

Non-Discrimination Law

Providers of CHIP services receive federal funds through the Department. Federal regulations specify that recipients of federal funds shall not discriminate in the provision of services and/or in employment practices as outlined in:

> Titles VI and VII of the Civil Rights Act of 1964 and the implementing regulations, prohibit discrimination on the grounds of race, color, sex, religion, or national origin;
>
> Section 504 of the Rehabilitation Act of 1973, Pub.L. 93-112, as amended by Pub.L. 93-516 and Pub.L. 95-602, 29 U.S.C.A. Section 794, and its implementing regulation, Title 45 CFR, Part 84, which prohibit discrimination on the basis of handicap;
>
> The Age Discrimination Employment Act of 1967 which prohibits employment discrimination based upon the factor of age; and
>
> Pub.L. 101-336, The Americans With Disabilities Act of 1990 which prohibits discrimination based upon handicap.

Discrimination Grievance Procedure

The Department's grievance procedure is outlined below. This procedure permits beneficiaries of programs monitored and/or administered by the Department, interested persons, and members of the public to file complaints of discrimination.

Copies of this procedure should be prominently displayed for public information and made available to anyone interested in filing a complaint. Additionally, a provider's policies on EEO and Nondiscrimination should be made available to the general public.

Questions regarding these requirements may be directed to the Department's Chief Personnel Officer at 444-3136 or write:

Chief Personnel Officer
Department of Public Health and Human services
PO Box 4210
Helena MT 59604-4210

Discrimination Complaint Procedure

The complaint procedure should be followed by anyone who is *not* a current employee of the Department. This includes applicants for agency employment or services, beneficiaries of Department programs and services, and/or members of the general public.

Any complaint relating to a discriminatory incident shall be presented in writing through the use of the Department's Discrimination Complaint Form. The written complaint must be submitted to the Department's Chief Personnel Officer at the address above within 15 working days of the alleged incident.

The Chief Personnel Officer or her designee shall have 30 working days from receipt of the written complaint to investigate the complaint and issue a written decision to the complainant (or his or her representative).

Anyone may file a formal complaint of discrimination at any time during the informal complaint process with the State Human Rights Commission. The time limit for filing a complaint under the Montana Human Rights Act is 180 days.

If alleging discrimination under a federal regulation, the complaint must be filed with the appropriate entity within the time limits prescribed by the law under which the claimant is filing.

Montana State Human Rights Commission
616 Helena Avenue, Suite 302
Helena MT 59601

US Dept. of Health & Human Services
Office of Civil Rights
1961 Stout Street, FOB Room 1185
Denver CO 80294-3538

Equal Employment Opportunity Commission
1801 L Street NW
Washington DC 20507

Discrimination Complaint Form

The form on the following page is required when submitting a written complaint relating to a discriminatory incident. The form must be submitted within 15 working days of the alleged incident in accordance with the procedures outlined above.

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
DISCRIMINATION COMPLAINT FORM (NON-DPHHS EMPLOYEES)

COMPLAINANT'S NAME: _____

MAILING ADDRESS: _____
_____
_____

PHONE NUMBER: _____(8:00 a.m. to 5:00 p.m.)

Specify the basis of discrimination (Check those applicable)

____ Sex
____ Race/Color
____ National Origin
____ Religion/Creed
____ Age
____ Handicap
____ Marital Status
____ Political Belief

Describe the action(s) resulting in discrimination: (attach additional sheets if necessary)

_____
_____
_____
_____
_____
_____

Date alleged discrimination occurred or began: _____

Specify individuals against whom discriminatory allegations are being filed: (name, work location, and phone number)
_____
_____
_____
_____

Specify corrective action you are seeking:
_____
_____
_____
_____

_____ _____
Date Complainant's Signature

Note: If this form is being prepared and submitted by anyone other than the complainant, please provide the name, address, and phone number of the complainant's representative(s).

NOTES